

# **Modernizing Michigan Medicaid Long-Term Care**

Toward an Integrated System of Services and Supports

*Final Report of*

**The Michigan Medicaid  
Long-Term Care Task Force**

*Established by Governor Jennifer M. Granholm via Executive Order No. 2004-1*

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## Preface

This report represents the culmination of many individual and group efforts starting in June 2004. From early on, the Task Force chose to adopt a positive attitude and create a vision of an ideal system as experienced by those the system is designed to serve. We were very aware of the fiscal constraints currently placed on state government. Despite these constraints, we did not lose our focus on the needs and desires of the many elderly, adults or children with disabilities, and caregiving families who are depending on the Task Force to make recommendations for reforming the long-term care system. With increased life expectancy, better medicine, and shifting demographics, many more Michigan citizens are projected to enter the system in coming years than ever before. By necessity as well as commission, the long view is imperative. There is also optimism that with more focus on prevention, chronic care quality outcomes, and support to informal caregivers, many will not need to enter long-term care who would have before. We are confident that these recommendations, if promptly implemented, will help Michigan's long-term care system to become increasingly robust and responsive to the needs of our citizens.

So many people have been involved that we may have omitted a few names of individuals and organizations in the appendix, but I would like to thank everyone for their individual and collective contributions. This has been a truly democratic effort, involving thousands of volunteer hours by hundreds of participants who attended workgroup meetings, composed reports, gave presentations, and shared their personal experience in testimony. Several organizations allowed us to use meeting space, staff time, equipment, and supplies. The number, diversity, and quality of people who were involved with the task force were impressive. We were not able to include all the fine detailed ideas produced by the workgroups, nor did we adopt them all, but we have made all their reports available on the task force web site at: <[www.ihcs.msu.edu/LTC](http://www.ihcs.msu.edu/LTC)>. Although the task force's work and formal existence is at an end, our network of relationships will continue to enable us to move forward to face Michigan's ongoing long-term care challenges in new venues.

RoAnne Chaney  
Chair, Michigan Medicaid Long-Term Care Task Force  
May 2005

## Executive Summary

The Michigan Medicaid Long-Term Care Task Force, appointed by Governor Jennifer Granholm, met between June 2004 and May 2005. It was charged with the duty to examine the long-term care (LTC) system and make recommendations to improve quality, expand the reach of home- and community-based services, and reduce barriers to an efficient and effective continuum of LTC services in Michigan. The task force responded by adopting a mission statement that emphasizes the role of consumer choice and by recommending the following policy changes:

1. Require and implement person-centered planning practices throughout the LTC continuum and honor the individual's preferences, choices, and abilities.
2. Improve access by establishing *money follows the person* principles that allow individuals to determine, through an informed choice process, where and how their LTC benefits will be used.
3. Designate locally or regionally-based "Single Point of Entry" (SPE) agencies for consumers of LTC and mandate that applicants for Medicaid funded LTC go through the SPE to apply for services.
4. Strengthen the array of LTC services and supports by removing limits on the settings served by MI Choice waiver services and expanding the list of funded services.
5. Support, implement, and sustain prevention activities through (1) community health principles, (2) caregiver support, and (3) injury control, chronic care management, and palliative care programs that enhance the quality of life, provide person-centered outcomes, and delay or prevent entry into the LTC system.
6. Promote meaningful consumer participation and education in the LTC system by establishing a LTC Commission and informing the public about the available array of options.

7. Establish a new Quality Management System for all LTC programs that includes a consumer advocate and a Long-Term Care Administration that would be responsible for the coordination of policy and practice of long-term care.
8. Build and sustain culturally competent, highly valued, competitively compensated and knowledgeable LTC workforce teams that provide high quality care within a supportive environment and are responsive to consumer needs and choices.
9. Adopt financing structures that maximize resources, promote consumer incentives, and decrease fraud.

The goal of these recommendations is to create an integrated system that appears seamless to the consumer, yet takes maximum advantage of the variety of LTC programs at the local, state, and federal levels. Specific recommendations for reducing barriers to an efficient and effective LTC system include expanding eligibility criteria, creating reimbursement mechanisms based on the acuity level of the consumer, and centralizing supports coordination in the SPE. Citizens will be better informed, involved, and prepared for their LTC needs through public education, participation in statewide and local commissions, and through financial incentives. The state will be better organized by centralizing its LTC planning and administration functions, which are currently scattered across departments.

Appended to this report is a Model Act, which is tentatively titled the "Michigan Long-Term Care Consumer Choice and Quality Improvement Act." It was drafted by a workgroup that sought to embody the task force's ideas in single document that may serve as a basis for legislative action. Although the task force recommendations may be enacted through a variety of means, the model act reinforces the idea that a cohesive, ongoing, and purposeful framework for the provision of LTC is needed in the state.

## Introduction: Transforming Michigan's Long-Term Care System

Michigan's publicly-funded long-term care (LTC) system faces a number of challenges, including fragmentation across programs, confusion among consumers and their families seeking access to LTC information and services, an over-reliance on relatively expensive institutional (nursing facility) care, and insufficient mechanisms to allow consumers to receive care in settings of their choice as their preferences and needs change. The state spends a relatively large proportion of its Medicaid long-term care budget on nursing facility services and significantly less on home- and community-based services (such as the MI Choice program). Current federal law, under the Americans with Disabilities Act and the *Olmstead* decision, requires that services for individuals who require LTC services be provided in the most integrated setting of choice possible. There must be an array of options available.

The state government lacks a central unit for coordinating current LTC programs and planning for future needs. The lack of a clearly articulated and consistently implemented strategy is felt on many levels. State residents spend an insufficient amount of time or resources planning for their LTC needs and are largely unprepared when the need (often suddenly) arises. Consumers lack a central place to receive information and support. Services are hard to maintain in some areas because direct care workers are often in short supply due in large part to under-compensation. This chaotic atmosphere will be intensified as waves of "baby boomers" continue to age and enter the system. The system needs to be rebalanced and centralized to serve the increasing needs of current and future consumers.

To address these concerns, the Michigan Medicaid Long-Term Care Task Force was created by Governor Jennifer Granholm via Executive Order No.1-2004 as an advisory body within the Department of Community Health. The charge given the task force by the executive order is to:

1. Review existing reports and reviews of the efficiency and effectiveness of the current mechanisms and funding for the provision of Medicaid long-term care services in Michigan and identify consensus recommendations.
2. Examine and report on the current quality of Medicaid long-term care services in Michigan and make recommendations for improvement in the quality of Medicaid long-term care services and home-based and community-based long-term care services provided in Michigan.
3. Analyze and report on the relationship between state and federal Medicaid long-term care funding and its sustainability over the long term.
4. Identify and recommend benchmarks for measuring successes in this state's provision of Medicaid long-term care services and for expanding options for home-based and community-based long-term care services.
5. Identify and make recommendations to reduce barriers to the creation of and access to an efficient and effective system of a continuum of home-based, community-based, and institutional long-term care services in Michigan.

The Task Force first sought to create the vision of an ideal system and then to identify the steps needed to attain it from the current system. The following Vision Statement was adopted at the August 9, 2004 meeting:

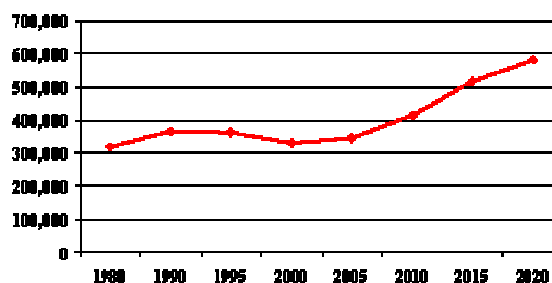
Within the next ten years, Michigan will achieve a high quality, easily accessible system of publicly and privately funded long-term care supports. These supports will include a full array of coordinated services available wherever an individual chooses to live and will be mobilized to meet the needs of each person with a disability or chronic condition, of any age, who needs and wishes to access them.

The arrangement and type of care and supports for each person will be determined by that person. Person-centered planning, which places the person as the central focus of supports and care planning, will be used to determine all facets of care and supports plans. Each person, and his or her chosen family, friends, or professionals, will initiate or re-start the process whenever the person's needs or preferences change.

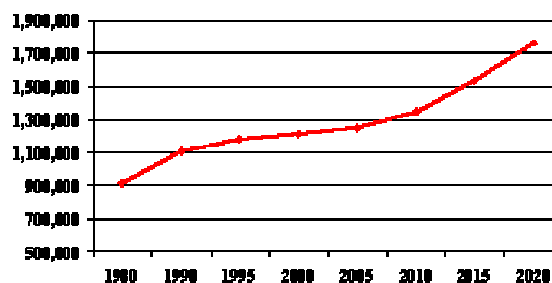
Many challenges exist in the effort to create an efficient and effective system of a continuum of home-based, community-based, and institutional long-term care services. The Task Force has identified some of the key issues through an intensive process of investigation and discussion.

We make the following recommendations to the governor and legislature.

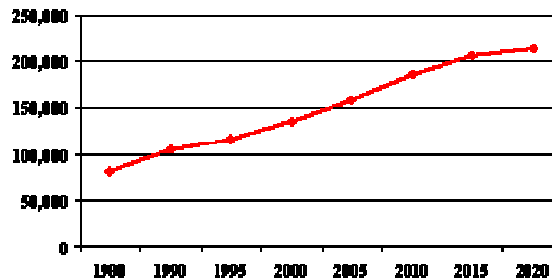
**Projected Growth in the 65-69 Year Old Cohort**  
Sizeable Increases in the Number of Retirees in Michigan



**The Escalating Aged Population (Projected)**  
Persons Over Age 65 in Michigan



**Fastest Growing Segment of the Elderly**  
85 Years and Older in Michigan (Projected)



Michigan Information Center population projections based upon U.S. Census data.

## Recommendations

The Task Force makes the following recommendations to improve the quality of Medicaid long-term care services and supports, the quality of home-based and community-based long-term care services and supports, and the quality of life for many citizens of Michigan.

### **Recommendation # 1: Require and Implement Person-Centered Planning Practices.**

**Current Issues:** Currently, long-term care services are delivered in a medical model manner. Various federal and state required assessment processes and forms are filled out to determine medical needs, financial eligibility, and other information focused on treatment and payment. As the authorizers of service and payment, professionals have the power to drive the care planning process. In some LTC settings, care conferences are often held without the presence of the person who is to receive the care. There may be claims that this practice is more efficient, but by making the consumer a passive receiver of care other problems may develop, such as learned helplessness, depression caused by lack of control over one's own life, and other psychological and physiological problems requiring additional treatment. Experiencing health care problems should not automatically strip people of control over their own lives and Michigan's LTC service delivery needs to reflect this value.

### **Recommended Actions**

The state should require and implement person-centered planning processes in statute and policy throughout the LTC system. As written in the Michigan Mental Health Code, "Person-centered planning" refers to "a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires." MCLA 330.1700(g). The process begins as soon as the

person enters the LTC system and continues as the person seeks changes. Person-centered planning is designed to allow people to maximize choice and control in their lives. A consumer-chosen supports coordinator/facilitator located at each SPE (see below) will help the consumer navigate through a full range of services, supports, settings, and options.

### **Strategies / Action Steps**

1. Require implementation of person-centered planning in the provision of LTC services and supports. Include options for independent person-centered planning facilitation for all persons in the LTC system.
2. Revise health facility and professional licensing, certification criteria, and continuing education requirements to reflect a commitment to organizational culture change, person-centered processes, cultural competency, cultural sensitivity, and other best practices.
3. Require all Single Point of Entry agencies to establish and utilize person-centered planning in their operations. Review and refine practice guidelines and protocols as part of the first year evaluation of the SPE pilot projects.
4. Include person-centered planning principles in model legislation to amend the Public Health Code.
5. Early in the implementation process, ensure the provision of training on person-centered planning to long-term care providers, regulators, advocates, and consumer.
6. Require a continuous quality improvement process to ensure continuation and future refinement of person-centered planning in all parts of the system.

### **Benchmarks**

1. Legislation requiring person-centered planning in the provision of LTC is passed in the current legislative session.
2. By January 1, 2006, the Department of Community Health, with the involvement of stakeholders, will establish in policy a person-centered planning protocol specific to LTC consumers.
3. Person-centered planning training is developed and provided to LTC providers, regulators, and advocates.
4. By October 1, 2006, each entity providing LTC services will have person-centered policies and training in place.
5. Regulatory survey and program monitoring processes are revised to include a review of the integration of person-centered planning in supports coordination activities.

### **Recommendation #2: Improve Access by Adopting “Money Follows the Person” Principles.**

**Current Issues:** There are currently different requirements for LTC clients to access services such as nursing homes, MI Choice waiver program, Adult Home Help, Adult Foster Care homes, Homes for the Aged facilities, and Program of All Inclusive Care for the Elderly (PACE). Some programs have a limited amount of access (MI Choice) and other programs are more available (nursing homes). Numerous other programs’ unique distinctions (i.e., allowable income levels) make it difficult for consumers to easily shift coverage from one program to another. Current eligibility policy attaches consumer benefits to providers and settings, rather than to individual unique needs.

### **Recommended Actions**

Establish a financing system that allows individuals to determine through an informed choice process where and how their long-term care benefits will be used. Individuals should have

a menu of services, settings, and providers from which to choose. “Money follows the person” refers to a system of flexible financing for long-term services that guarantees individuals receive their preferred services and supports in the environment of their choice at all times. The money literally does not belong to nor follow an individual. It is simply a principle that customized services necessary to meet specific needs are available and that consumers drive decisions as they move through the LTC system. Access to different types and amounts of supports becomes seamless and relatively easy from the consumer’s perspective and changes with consumer’s needs or wishes. “Money follows the person” is a concept that allows an individual to receive necessary services when they want, where they want, and how they want these services delivered.

### **Strategies / Action Steps**

1. Establish consistent spend down provisions across all long-term care settings.
2. Establish funding mechanisms that abide by the “money follows the person” principle.
3. Amend and fund the MI Choice waiver to serve all eligible clients.
4. Establish reimbursement levels that realistically and appropriately reflect the acuity level and need for services and supports the client needs, consistent with federal limitations. (An immediate step would be to remove the current reimbursement cap on the MI Choice waiver.)



### **Benchmarks**

1. Medicaid state plan is amended to establish spend down provisions for community-based LTC settings.
2. Medicaid-funded LTC services and supports are reimbursed based on a case mix basis.
3. Mechanisms are in place to allow consumers to port benefits across the multitude of LTC services and environments of their choice to the extent permitted under federal regulation.
4. Effective October 1, 2005 and quarterly thereafter, MI Choice waiver program enrollment and funding are incrementally increased to meet demand for MI Choice services to eliminate the need for waiting lists.

### **Recommendation # 3: Create Single Point of Entry Agencies for Consumers.**

**Current Issues:** Michigan citizens needing long-term care services, for themselves or for loved ones, lack a centralized, neutral source of information and assistance. As they navigate through the maze of programs, they may not find the best mix of services and supports to suit their needs. Many simply are placed in nursing facilities because Medicaid provides funding and because they may not be aware of other options. Consumers also need assistance developing their person-centered plans and coordinating their supports.

### **Recommended Actions**

Create locally or regionally-based “Single Point of Entry” (SPE) agencies for consumers of long-term care using person-centered planning process. DCH, or the proposed LTC administration, will oversee the SPE agencies. A SPE is defined as “a system that enables consumers to access long-term and supportive services through one agency or organization. In their broadest forms, these

organizations manage access to one or more funding sources and perform a range of activities that may include information and assistance, preliminary screening or triage, nursing facility preadmission screening, assessment of functional capacity and service needs, care planning, service authorization, monitoring, and reassessment.” (Source: “Single Entry Point Systems: State Survey Results.” Prepared by: Robert Mollica and Jennifer Gillespie, National Academy for State Health Policy).

SPE agencies will provide information, referral, and assistance to individuals seeking LTC services and supports. They will have trained staff and the ability to serve clients who do not speak English. Assistance must include supports coordination and authorizing (but not providing) Medicaid services. They also must serve as a resource on LTC for the community at large, including caregivers. Use of the SPE agency should be mandatory for individuals seeking to access Medicaid funded LTC programs.

### **Strategies / Action Steps**

1. Determine financial eligibility through the appropriate state agency. The process of determining eligibility also helps capture other public and private assistance programs for which the person is eligible. The SPE agencies will provide assistance to consumers in working through the eligibility application process. Single points of entry can facilitate speedier processing and identify barriers to processing. SPE agencies should work with other agencies to resolve barriers found in the system.
2. Make supports coordination a key role of the SPE agencies. Consumers have the ability to change supports coordinators when they feel it is necessary to do so. Individuals should develop their support plans through the person-centered planning process. If the consumer chooses a supports coordinator from outside of the agency, the outside supports coordinator is held to the same restrictions on financial interest and should be held to same standards as SPE

supports coordinator. The SPE retains the responsibility of authorizing services.

- a. The consumer can choose to have their supports coordinator broker their services or may broker their own services - whichever they prefer.
  - b. The SPE agency will develop a protocol to inform consumers of their right to change supports coordinators.
  - c. Establish methodologies to facilitate consumer control of what, by whom, and how supports are provided. Included will be methodologies for consumers to control their budgets or authorizations.
3. Make LTC transition a function of the SPE agencies. This service helps consumers make decisions about their own lives and facilitates a smooth transition between settings as their needs and preferences change.
  4. Balance LTC through proactive choice counseling. The goal of proactive choice counseling is to catch people with LTC needs at key decision points (such as hospital discharge) and provide education and outreach to help them understand their options. Involve hospital administrators and social workers in developing protocols for the two systems to work together. This will involve outreach by the SPE to hospitals to explain their functions and benefits. Do outreach to the local physician community as well as other interested parties (Adult Protective Services, police, and others) working in settings where critical decisions are made about long-term care.
  5. Mandate use of the SPE agency for individuals who seek to access Medicaid-funded programs. Individuals who are private pay will be able to access all of the services of the SPE agency. The Information and Referral/Assistance

functions will be available to everyone at no cost. Private pay individuals may have to pay a fee to access other SPE services (such services may be covered by long-term care or other insurance, however). LTC providers will be required to inform consumers of the availability of the SPE agency.

6. Make a comprehensive assessment, or level of care tool, (developed by the proposed LTC Administration) available from the SPE agencies to determine functional eligibility for publicly funded LTC programs including Home Help, Home Health, Home and Community Based Services waiver (MI Choice), and nursing facilities. SPE agencies will use the Comprehensive Level of Care Tool for all persons coming to the SPE for assessment. The LTC Administration or MDCH is responsible for the development of the comprehensive tool. The SPE is responsible for ensuring the Preadmission Screening and Annual Resident Review (PAS/ARR) screen is done by the responsible agency when appropriate.
7. Require providers of LTC services to offer the Level of Care Determination Tool to private pay consumers. If a provider feels it cannot perform this assessment for the consumer, the provider should avail itself of the SPE agency's ability to perform this function.
8. Locate functional eligibility determination in the SPE agencies as long as there is aggressive state oversight and quality assurance including: 1) SPE agency required procedures to prevent provider bias and promote appropriate services; 2) SPE agency supervision, monitoring, and review of all assessments and support plans/care coordination; 3) state quality assurance monitoring; and 4) consumer advocate and ombudsman monitoring.
9. The SPE agencies cannot be a direct provider of services to eliminate the tendency to recommend its own services to consumers and any other conflicts of

interest. (An exceptions process must be developed to address service shortfalls, but in no event shall a SPE be a direct provider of Medicaid services.) The case management currently done by Waiver agents would be provided through SPE agencies under this system. The case management done by Department of Human Services (DHS) for Home Help would be provided through SPE agencies in this system. SPE agencies will encompass the entire array of Medicaid funded LTC supports.

10. The funding for defined single points of entry is estimated to be between \$60 and \$72 million statewide. Of this total, approximately \$31 to \$36 million represents “shifted” dollars from current case management resources, while the remaining amount reflects newly committed dollars needed for this purpose. The annual state share of newly committed dollars upon full implementation (at the end of year 3) will be \$15 to \$20 million. The Medicaid administrative matching formula should be used as the means of funding the SPE system.

The SPE system will be phased-in over a three-year period. The estimate for first year costs for three SPE agencies is \$12 to \$16 million total funds. The State’s GF contribution would be \$6 to \$8 million of which \$3 to \$4 million would be cost-shifted. SPEs will be routinely evaluated to ensure the needs of consumers are being met effectively and efficiently. A system wide efficiency gain of 1.7% in LTC expenditures as a result of establishment of single points of entry will fund the entire state system.

11. Develop a standard set of training and certifying criteria for SPE agencies set by the state. By establishing a standard set of certifying criteria, the state will be able to establish quality assurance measures that will provide consistency for consumers and stakeholders. Part of the standard criteria should be a

demonstrated knowledge of local and regional resources to supplement Medicaid-funded supports.

12. Standardize the tools used by SPE agencies to allow for portability of benefits for the consumer if they move between regions as well as standardization of data collection for the state.
13. Ensure access to bilingual and culturally competent staff at single points of entry who are trained according to the requirements of the SPE agencies.
14. Implement a quality assurance function focused on the SPE agency that emphasizes, but is not limited to, measures of consumer satisfaction.
15. The state needs to establish a comprehensive oversight system to ensure that all LTC consumers receive those supports and services set forth in their person-centered plan in a timely manner and that the supports and services are of the highest quality possible. Quality in this context will be measured by the consumer’s satisfaction or lack thereof with the supports as provided.
16. Expand advocacy processes for all LTC consumers. An advocate must be designated and legally granted the duty and authority to advocate on behalf of individual long-term care consumers, since much expertise is required for effective advocacy. The advocacy function also needs to have a systemic approach to advocacy, similar to that performed by the State Long-Term Care Ombudsman or Michigan Protection and Advocacy Services. This more systemic approach would provide greater opportunity for the advocacy group to determine if there are any patterns of policy violations by SPE agencies or for patterns of misunderstandings of the policies by consumers or providers.

17. Develop grievance and appeals processes that empower LTC consumers to challenge any denial of a requested support or any reduction, termination, or suspension of a currently provided support. The grievance process must be available not only for those issues, but also for issues not typically subject to the appeals process (such as the choice of provider).

### **Benchmarks**

1. SPE agencies initially established in three areas of the state within one year of the issuance of the Task Force report.
2. SPE agencies established throughout the state within three years from the issuance of the Task Force report.
3. In the absence of the LTC Commission, DCH will convene a workgroup of consumers, advocates, providers, and DCH officials that will develop a more detailed list of criteria using the recommendations in this report as a foundation to be met by a SPE agency by July 30, 2005. The workgroup should also approve the regions.
4. DCH or the LTC administration will issue an RFP for early adopters (the first three local SPE agencies). The RFP should require local support and collaboration but not prescribe which agencies can apply as early adopters. The state needs to ensure the recommended agency can meet the standards set by the state. At the time the RFP is issued, MDCH or the LTC Administration should hold briefings for interested agencies on the components of the RFP.
5. DCH, or the LTC Administration, will evaluate early adopters to determine if they are achieving the anticipated results. Information gathered during this evaluation should be used in the development of other SPE agencies.
6. DCH, or the LTC administration, will develop preliminary quality assurance

guidelines in time for the RFP that will be issued for the first round of SPE development. This will allow applicants to respond to how they meet quality assurance expectations up front.

7. The outside advocate is adequately funded to assure consumer access in all geographic SPE areas.
8. SPE agencies have local quality assurance boards composed of a majority of consumers, with representation by other stakeholders that are reflective of the communities in which they are located. Functions might include CQI, feedback to governing board, and LTC administration.
9. Agencies responding to the RFP to be an SPE will have an appeals protocol written into their proposals.
10. DCH or the LTC administration will assure that Medicaid Fair Hearing processes are made available to SPE participants.
11. An agency applying to be an SPE should be able to provide a qualified Information and Referral service (such as those certified by AIRS).
12. Hospital discharge planners will contact the SPE at admission to begin the process of assessing needs instead of at discharge.
13. Physicians will coordinate with supports coordinators and consumers to ensure the best outcomes for the consumer. Memoranda of Agreement will be created between hospitals and single points of entry to make this process as smooth as possible.
14. Consumers and their loved ones will have a clear idea of their options.
15. An assessment system and process will be developed that:
  - a. Includes a standard minimum intake screen that predicts need for the full array of Medicaid funded LTC programs and efficiently identifies areas for further evaluation.

- b. Incorporates person-centered planning as the starting point for assessment and goal development.
  - c. Implements specific evidence-based assessment protocols when triggered by the minimum intake screen.
  - d. Includes a comprehensive caregiver assessment when indicated.
  - e. Utilizes an electronic database that serves as a base for information, documents assessment and planning history, and follows the individual through the full array of long-term care supports.
16. DCH will train single points of entry on the new tool and test it before applying it system wide.

**Recommendation # 4: Strengthen the Array of Services and Supports (Expanding the Range of Options).**

**Current Issues:** The Michigan LTC service delivery system is fragmented. Access to community-based LTC settings, services, and supports is limited as a result of caps placed on enrollments and expenditures and financial eligibility. Nursing facility enrollment and expenditures are capped by the availability of a licensed bed and the willingness of a provider to admit a Medicaid recipient. Further limiting access is Michigan policy that establishes patient pay provisions for Medicaid coverage for nursing facility care, provisions that do not exist for home and community-based settings. If an individual is over the income limit the only Medicaid LTC

option becomes the nursing facility. There is a lack of affordable setting options between the home and the nursing facility. Michigan policy does not allow individuals who qualify for waivers to receive those services in licensed assisted living settings (adult foster care or homes for the aged). This negates their use as a viable alternative to nursing facility placement. There is a lack of coordination between the health and long-term care service delivery systems, with no incentive for systems to interact.

Chart 1 on the next two pages lists the array of 53 preferred LTC services. It reflects the various existing programs across different funding sources and departments. The consumer wishing to know what services are available is often confused in the process of accessing care.

Chart 2 (on page 13) illustrates the fact that different programs use different criteria for financial eligibility, clinical assessment, quality, oversight, and cost reporting. The combination of a wide array of services with no common eligibility criteria leaves the customer with the need for a “guide” to help them understand, choose, and access needed services. The SPE will act as this “guide”.

Ideally the single points of entry would have one eligibility tool. The state should investigate a method to achieve that. Such a future would greatly enhance a seamless experience for the consumer. Individuals whose LTC services are funded with Medicaid dollars should have full access to the same range of services, supports, and settings available to the general public.

Chart 1 Proposed LTC Continuum		Medicaid Eligible Services	HCBW	Home Help	Home Health	OSA OAA	PACE	NH	CMH	DD/MR Waivers	MH State Plan Services
1. Adult Day Care			X			X	X		X		
2. Ambulance		X					X				
3. Assessment			X	X	X	X	X	X	X(PASARR)		X
4. Assisted Living	Includes licensed AFCs/HFAs, services and room/board						X (But no room & board payment)		X	Under CLS*	X (Only in licensed ICF/MR certified settings)
5. Assistive Technology	Includes any device that improves a person's functioning	X	X	(Through Physical Disability Services)			X	Some		X	X
6. Behavioral Health		X					X		X	X	X
7. Case Coordination/ Supports Facilitation	Single coordinator across all settings		X	X		X	X			X	X
8. Caregiver Education						X	X		X	X	
9. Caregiver Support						X	X		X	X	
10. Chiropractic Services		X					X				
11. Chore Services		X	X	X		X	X			Under CLS	Under CLS
12. Chronic Care Management	Focus on consumers and all their needs rather than on medical diagnosis	X			X		X			Uses person- centered planning	Uses person- centered planning
13. Counseling	Includes individual & family		X			X	X	X	X	X	X
14. Dental Services							X			Enhanced	In ICF/MR
15. Diagnostic Services		X					X		X	X	X
16. Emergency Services		X					X		X (Crisis Intervention)	X	X(Crisis Intervention)
17. Employment Services						X (SCSEP- related)			X	X	X(as Habilitation)
18. Expanded State Plan Benefits			X				X				
19. Family Planning Services		X								person- centered planning could cover	person- centered planning could cover
20. Financial Management							X		Guardianship	Under CLS	
21. Fiscal Intermediary				X						X	
22. Gap Filling Services			X			X	X		X		X
23. Hearing & Speech Services	Includes hearing aids	X				X	X			X(Enhanced)	X
24. Home Modification/ Repair	Includes ramps		X			X (Limited)	X		X	X	
25. Homemaker			X	X		X	X		X	Under CLS	
26. Hospice	Includes residential care (room and board)	X					X	X			
27. Hospital Care	Includes in-patient, out- patient	X					X				X
28. Immunizations		X					X				
29. Laboratory Services		X					X				
30. Medical Equipment/ Supplies		X			X	X	X		X	Enhanced	

Chart 1 Proposed LTC Continuum		Medicaid Eligible Services	HCBW	Home Help	Home Health	OSA OAA	PACE	NH	CMH	DD/MR Waivers	MH State Plan Services
31. Medication Management		X	X	X		X	X	X	X	Under CLS	X
32. Nursing Services			X		X		X	X	X	X	X
33. Nursing Facility Services	Includes innovative service delivery models	X					X	X			X
34. Nutrition Services	Includes meal prep, home delivered meals, dietary services		X	X	X	X	X	X		Under CLS	In ICF/MR
35. Personal Assistance Services	Includes personal care, supervision, attendant care	X	X	X	X	X	X	X	X	Under CLS	In ICF/MR
36. Personal Emergency Response			X			X	X			X	
37. Pharmacy		X					X		X (Counseling)	X(Enhanced)	
38. Physician Services	Includes visiting physician	X					X	X			In ICF/MR
39. Podiatric Services		X					X				In ICF/MR
40. Prevention	Includes primary and secondary, and wellness activities					X (Health Screening/ Promotion)	X		X		
41. Psychiatric Services		X					X		X		In ICF/MR
42. Refugee Services	Includes interpretive and cultural services					X (2 AAAs Admin. FIA Grants)					
43. Rehabilitation Services		X					X	X	X	X (Habilitation Services)	In ICF/MR
44. Respite	In-home and out-of-home		X			X	X		X	X	
45. Shopping/Errands		X	X	X		X	X			Under CLS	
46. Supervision		X	X				X	X		Under CLS	In ICF/MR
47. Therapies	Includes occupational, physical, speech and maintenance therapies	X					X	X	X		In ICF/MR
48. Training	For consumers & caregivers		X			X	X		X		In ICF/MR
49. Transition Services			X				X		X		Under TCM
50. Transportation	For medical and socialization purposes	X	X			X	X			Under CLS	X
51. Urgent Care Services		X					X				X (Psych.)
52. Ventilator Services		X	X				X	X			In ICF/MR
53. Vision Services	Includes eyeglasses	X					X				In ICF/MR
<b>MEDICAID COST:</b>		<b>40 current services \$1.58 billion</b>	<b>\$100 million</b>	<b>\$216 million</b>	<b>\$25.6 million</b>	<b>\$85 million</b>	<b>\$5.3 million</b>	<b>\$1.2 billion</b>	<b>\$1.6 billion total MH</b>	<b>\$5 million</b>	

\*CLS = Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his/her goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

**Chart 2**

LTC Service	Acuity Assessment Tool	Quality Measures			Cost Data
<b>Nursing Homes<sup>1</sup></b>	MDS, LTC Eligibility Screen	Family & Resident Satisfaction, Consumer Guide	Quality Indicators (MDS) CMS	OBRA Survey & Complaints (DCH), State Ombudsman (OSA)	Medicaid Cost Reports; Expenditures per person through Medicaid data warehouse
<b>HCBS<sup>3</sup></b>	MDS, LTC Eligibility Screen, MICIS Screen	Client Satisfaction	Vendor Assessments; Care Plan Monitoring	Grievances & Complaints	Medicaid Cost Reports; Expenditures per person through Medicaid data warehouse
<b>Home Help<sup>4</sup></b>	DHS Assessments of ADL & IADL Needs	Client Satisfaction	Administrative Hearing Process	Care Plan Monitoring	Expenditures per person through Medicaid data warehouse; Costs per acuity level available through ASCAP random sample studies
<b>Home Health<sup>2</sup></b>	OASIS (Outcome and Assessment Information Set)	Patient Satisfaction, Consumer Guide	OBQI	Accreditation Medicare State Survey; Complaint Process (DCH)	Expenditures per person through Medicaid data warehouse Cost Reports MC, MA, BC/BS
<b>AFC/HA<sup>4</sup></b>	DHS Assessments of ADL & IADL Needs	Client Satisfaction	Administrative Hearing Process	Licensing Survey & Complaint Process Care Plan Monitoring	
<b>Hospice<sup>2</sup></b>		National Hospice Patient Care Family Satisfaction		Licensing Survey, MC State Survey, Accreditation	Expenditures per person through Medicaid data warehouse Cost Reports MC, MA
<b>PACE<sup>4</sup></b>	LTC Eligibility Screen	Annual & Quarterly Reports to DCH: Satisfaction Surveys, Quality Improvement Program, Grievance & Appeals Report	Survey site visit tool for annual DCH site visit (various items, including random sample of medical records)	CMS PACE monitoring reports (various items, including grievances, unusual incidents, deaths)	Existing PACE will soon be submitting encounter data
<b>OSA: Annual Contracts<sup>3</sup></b>		Client Satisfaction		Annual Assessment; Performance-Based Contract	National Aging Program Information System; Financial Status Reports
<b>OSA: Purchased Services<sup>3</sup></b>	MICIS Assessment Tool for LTC Eligibility	Client Satisfaction	Care Plan Monitoring	Assessments; Grievances & Complaints	

1. Nursing Home information from Health Care Association of Michigan;
2. Home Health & Hospice information from Michigan Home Health Association;
3. HCBS and OSA information from Gregory Piaskowski; and
4. Other information from Department of Community Health.



## **Recommended Actions**

Establish an accessible, integrated service system that assures those in need of supports and services have a range of options that allow them to live where they choose. Within an assessed level of need, consumers should have a menu of services and settings to choose from based on their individual preference. Service delivery should be coordinated with existing providers and payers, including private payers, and provided in a wrap-around capacity. (In the case of persons who desire to work, this includes services and supports for vocational and employment activities.)

## **Strategies /Action Steps**

1. Ensure the availability of the health and long-term care services and supports (listed on Chart 1) as part of an integrated system of care.
2. Immediately amend the MI Choice waiver to allow the provision of waiver services to individuals residing in licensed assisted living settings including adult foster care homes and homes for the aged. In addition to this short-term strategy, take measures to ensure that all future comparable Medicaid programs allow supports and services to follow consumers into their preferred living arrangement (money follows the person).
3. Revise Adult Foster Care (AFC) and Homes for the Aged (HFA) rules and regulations to allow for the provision of home health care in AFCs and HFAs on an ongoing basis.
4. Consider creating a HFA statute separate from the Public Health Code.
5. Create an Assisted Living Regulatory and Education Workgroup and charge with the following tasks:
  - a. Study and propose modifications to existing adult foster care and home for the aged state statutes and

administrative rules for the purpose of ensuring that they meet with the Task Force's stated philosophies and principles of quality and accountability; person-centered planning; money following the person and the availability of Medicaid reimbursement in assisted living (such as the MI Choice waiver or comparable community-based benefits).

- b. Study the array of unlicensed assisted living arrangements. Determine whether existing licensing statutes are appropriately enforced to uphold the philosophies and principles stated above.
- c. In cooperation with other Task Force initiatives, develop consumer education materials to be used by SPE agencies and others to raise consumer awareness about the full array of assisted living services using clear distinctions regarding the applicable state regulations.
- d. Determine the feasibility and appropriateness of developing a legal definition of "assisted living" to allay public confusion as to the meaning of the term and its current use in describing a wide variety of licensed and unlicensed settings.

The task force concluded that the development of a more formal legal definition of "assisted living" is best delayed until the preceding steps have been taken and recommends that the following interim description of the term "assisted living" be universally understood in the Medicaid Long-Term Care Task Force report:

"The term 'assisted living,' as currently used in Michigan, is a marketing term often used by supported living arrangements such as state licensed adult foster care homes (MCL 400.703 through 400.707), state licensed homes for the aged (MCL333.20106(3)), unlicensed

settings such as housing with services contract establishments (MCL 333.26501(b)) and other supported independent living arrangements.”

#### **Benchmarks**

1. Array of services is expanded for consumers.
2. Amendment of existing MI Choice waiver to allow the provision of waiver services to individuals in licensed assisted living settings.
3. Creation of an Assisted Living Regulatory and Education workgroup to study issues related to definition, licensure, and regulation, and to suggest ways to amend them to remove barriers that limit services in assisted living facilities.

**Recommendation # 5: Support, Implement, and Sustain Prevention Activities through (1) Community Health Principles, (2) Caregiver support, and (3) Injury control, Chronic Care Management, and Palliative Care Programs that Enhance the Quality of Life, Provide Person-Centered Outcomes, and Delay or Prevent Entry in the LTC system.**

**Current Issues:** Strong prevention and caregiver support programs have the potential to increase the quality of life for disabled and elderly citizens and delay entries or shorten stays in the long-term care system. The stress of intensive care giving, in many cases, contributes to increased health care and long-term care needs for the caregivers (such as elderly spouses). Currently, Medicaid does not support preventive health programs and, as the Michigan population ages, the numbers of seniors with multiple chronic diseases will increase unless early interventions are offered.

#### **Recommended Actions**

1. Develop and provide incentives for local collaboration, including public health, to actively promote healthy aging through preventive and chronic care for all age groups.
2. Develop and implement legislative/ administrative initiatives to provide financial and other support to caregivers. Natural supports are sustained.
3. Increase the use of “best” chronic care models.

#### **Strategies / Action Steps**

Develop a DCH workgroup comprised of legislators, MSA, OSA, DHS, stakeholders / consumers, and others to oversee the collaborative process involving local public health entities engaged in prevention/chronic care. Under the direction of the DCH-led workgroup, local entities will:

1. Convene a broad-based coalition of aging, disability, and other organizations.
2. Review community resources and needs (including prevention, chronic care, and caregiver supports).
3. Identify existing local, culturally competent strategies to address prevention, chronic care needs, and substance abuse.
4. Develop and support programs to address prevention, chronic care, and caregiver supports.
5. Promote the use of culturally competent caregiver training on injury prevention, rights and benefits, and person-centered planning.
6. Develop wrap-around protocols for caregiver/consumer support needs.
7. Develop a public health caregiver support model.
8. Create initiatives and incentives to support caregivers.

9. Identify and promote the use of elements of established models for chronic care management and coordination (e.g., Wagner or ACOVE model).
10. Create incentives for implementing culturally competent chronic care models and protocols.
11. Develop and implement chronic care protocols, including, but not limited to:
  - a. medication usage.
  - b. identifying abuse and neglect, caregiver burnout/frustration.
  - c. caregiver safety and health.
12. Promote the use of Assistive Technology (AT) for consumers and direct care workers/caregivers as a prevention tool.
13. Investigate grant opportunities to pilot chronic care management models.

#### **Benchmarks**

1. Needs assessments are conducted and gap analysis reports are completed and reviewed.
2. Local and statewide groups complete plans to address local health and wellness gaps.
3. Executed contracts in place with local existing entities, which are broad-based (including the aging and disability community) to address gaps.
4. Completed workgroup report evaluating progress, outcomes, and identifying next steps.
5. Every local region has a program in place to train caregivers that is culturally competent to the needs and culture of the informal caregiver.
6. Consumer supports are increased and better utilized.
7. Caregiver needs screening incorporated into Medicaid-funded screening instruments.
8. Upon retrospective review, address caregiver needs.

9. Registries completed with processes in place for ongoing updates.
10. Legislative and administrative initiatives are in place and used.
11. Increase in the number of primary and LTC providers trained and adopting the best chronic care and culturally competent models.
12. Medical schools and nursing/ancillary healthcare programs expand their curricula to include chronic care.
13. Increased numbers of students graduating from schools with established chronic care curricula/programs.
14. Increased number of providers using screens and protocol-driven interventions.
15. Increased use of assistive technology as reflected in the person-centered plan.

### **Recommendation # 6: Promote Meaningful Consumer Participation and Education by Creating a Long-Term Care Commission and Informing the Public about the Available Array of Long-Term Care Options.**

#### **A. Long-Term Care Commission**

**Current Issues:** In order to create a long-term care system that is based on consumer choice and control, consumers and their representatives must have a meaningful role in the development and oversight of the system.

#### **Recommended Action**

Create a Michigan Long-Term Care Commission to provide meaningful consumer oversight and accountability to the state's reform and rebalancing of the long-term care system.

#### **Strategies / Action Steps**

All stakeholders will have meaningful roles in the ongoing planning, design, implementation, and oversight efforts to achieve the recommendations of the Michigan Medicaid Long-Term Care Task

Force and the long-term care efforts of the state. Consumers, families, and their representatives will be the principal participants.

#### Appointment

The Michigan Long-Term Care Commission will be established in state legislation with the governor appointing members with concurrence of the state senate for three-year staggered terms.

#### Membership

1) The commission shall consist of twenty-five members appointed by the governor.

Commission membership shall consist of fourteen consumers, of which at least fifty percent are primary consumers and of those primary consumers, at least fifty percent shall be users of Medicaid services, the remainder comprised of secondary consumers and consumer organization representatives, seven providers or provider organization representatives, three direct care workers and one member with expertise in LTC research from a university. Overall commission membership shall also reflect the geographic and cultural diversity of the state.

2) One representative each from the SPE network, the State Long-Term Care Ombudsman, the designated protection and advocacy system, the Department of Community Health, the Department of Human Services, and the Department of Labor and Economic Growth, all of whom shall serve in non-voting supporting roles as ex-officio members. Staff shall be provided and shall serve as resources to the commission and shall assist the commission as needed.

3) Voting member terms shall be three years, staggered to ensure continuity and renewable under the appointment process. If a vacancy occurs during the term of a voting member, the governor shall appoint a replacement to serve out the remainder of the term and shall maintain the same composition for the commission as set forth in sec. 1.

4) Commissioners are entitled to receive a stipend, if not otherwise compensated, and reimbursement for actual and necessary expenses while acting as an official representative of the commission as

defined by commission policies and procedures. Commission policies and reimbursement shall establish and practice full accommodation to individual support needs of commission members, including their direct care and support workers or personal assistants, support facilitation or other persons serving them as secondary consumers.

5) The governor shall designate one person from among the consumer membership to serve as a chairperson of the commission, who shall serve at the pleasure of the governor.

#### Authority

##### 1.) Policy and Programs

In partnership with the executive branch and the appropriate department or designated long-term care entity, the Commission will develop and recommend policy regarding all LTC programs including the public awareness and education campaign.

##### 2.) Budget

In partnership with the executive branch and the appropriate department or designated long-term care entity, the Commission will participate in the development of the budget for Michigan's LTC system that implements established policy and meets demonstrated consumer preferences and needs. The commission will make recommendations regarding the same to the legislature.

##### 3.) Spending

The Commission will continuously monitor spending and budget implementation including how well expenditures match policy decisions and initiatives based on demonstrated consumer preferences and needs.

##### 4.) Performance and Quality of Single Point of Entry Agencies

The Commission will help develop and approve quality assurance measures for monitoring the efficiency, effectiveness, and performance of local initiatives including local oversight of and consumer involvement with the SPE agencies. Once the LTC commission is established, it will work with DCH or the LTC administration in the selection and oversight of the agencies.

Using the evaluations and feedback from the performance and quality assurance monitoring done by the department, the Commission will make recommendations to improve the operational performance of SPE agencies and shall make its report and recommendations for improvement to the single point of entry system available to the legislature and the public.

The Commission will play a similar role for all other entities in LTC including new initiatives involved in rebalancing the system.

#### **Benchmarks**

1. Passage of authorizing legislation creating LTC Commission.
2. Appointment of Commission members.
3. Reporting by Commission members, both consumers and others that they have the information and support to effectively carry out the Commission's duties.
4. Surveys of consumers using the SPE agencies to demonstrate that the available services and supports and opportunities for consumer choice and control correspond with what they need and want.

#### **B. Public Awareness and Education Campaign**

**Current Issues:** Individuals, families, professionals, and others are not aware of LTC options and are unprepared when a decision needs to be made. Short time frames for decision-making and the complexity of the system, for example, do not allow consumers to fully investigate and understand their options.

#### **Recommended Actions**

Educate consumers, families, service providers, and the general population about the array of long-term care options available so that consumers can make informed choices and plan for the future.

The goals of the public awareness and education campaign are:

1. Increase awareness of the SPE agencies through uniform "branding" of local agencies throughout the state (with uniform naming and logo, a single web site, and a geo-routed toll free number).
2. Increase awareness among consumers, prospective consumers, providers, faith-based communities, other community organizations, neighbors, friends, and family members of LTC services that consumers can choose from the array of LTC supports, determine their needs through the person-centered planning process, and have the option to control and direct their supports.
3. Authorize continuing education for professionals (including doctors, nurses, pharmacists, dentists, psychologists, administrators of LTC facilities, discharge planners, social workers, and certified nursing assistants) on the role of the SPE agency, the value of the person-centered planning process, the array of long-term supports available, and options for consumers to direct and control their supports. These professionals can direct individuals to the single point of entry and support them in making informed choices and planning for their future.

4. Assure that state employees involved in any aspect of LTC are provided mandatory training on the value of the person-centered planning process, the array of LTC supports available, and options for consumers to direct and control their supports.
5. Provide an orientation to legislators and their aides and officials in the executive branch on the value of person-centered planning, the array of long-term supports available, and options for consumers to direct and control their supports.
6. Create an educational program for children K-12 to learn about career opportunities in direct care and other aspects of LTC, and the components of the new LTC system (the array of long-term care supports available, the value of the person-centered planning process, and options for consumers to direct and control their supports) so that children can share this information with their family members.

### **Strategies / Action Steps**

1. Develop criteria for and authorize hiring of a social marketing firm to develop a marketing and public awareness campaign that includes the following components:
  - Uniform identity including name and logo for the single point of entry agencies;
  - Public awareness campaign that includes radio and television public service announcements, print ads, brochures, and other appropriate educational materials; and
  - Local media and awareness tool kit that single point of entry agencies can use to outreach to and raise awareness among all stakeholders.
2. Develop criteria for and authorize hiring of a web design firm and an expert in creating materials for the targeted populations (e.g., seniors and people with a variety of disabilities) to design an informative, user

friendly web site that can serve as a single point of information regarding LTC in Michigan. This web site will maintain the look, name, and logos developed for the marketing and public awareness campaign. The web site will include comprehensive information on LTC, have well-developed keywords and navigation capabilities, and be linked to major search engines and other relevant web sites in a way that makes them easily accessible.

3. Establish criteria for and authorize the development of curricula for education of professionals (including doctors, nurses, pharmacists, dentists, psychologists, administrators of LTC facilities, discharge planners, social workers, and certified nursing assistants) that can be included in academic programs and continuing education requirements for licensing and/or certification and will be implemented over time.
4. Establish criteria for and authorize development of a variety of training and educational materials targeted to the specific groups described above (state employees involved in long term care, legislators and their aides, and children K-12).

### **Benchmarks**

1. Development of campaign materials including radio and television public service announcements, print ads, brochures, and other appropriate educational materials.
2. Dissemination of campaign materials:
  - a. Measured by number of media placements and numbers of materials distributed.
  - b. Measured by the impact as identified by consumers, family members, and professionals that interact with the Single Point of Entry agencies.
3. Development of curricula targeted to the identified professional and educational groups.

4. Implementation of curricula targeted to the identified professional and educational groups.
5. Measured by the number of individuals that complete a curriculum or other educational program.
6. Measured by the referrals to the SPE by the professionals.
7. Measured by consumer reporting of the content of the professional interaction (i.e., if and how the professional made a referral to the SPE and whether the professional described the potential for consumer choice and control).

### **Recommendation # 7: Establish a New Quality Management System.**

**Current Issues:** A quality long-term care experience is an individual evaluation. Quality is defined and measured by the person receiving supports, and not through surrogates (payers, regulators, caregivers, families, professionals and/or advocates). The elements of quality are meaningful relationships, continuity of community involvement in the person's life, personal well-being, performance measures, customer satisfaction measures, the dignity of risk taking, and the freedom to choose or refuse available options.

The task force members agree that a high quality LTC system of support and services must recognize the primacy of the consumer as center of any assessment or evaluation of the quality of the system. The consumer's needs, experiences, and satisfaction are the lenses through which any quality assurance effort must be viewed.

Oversight of the LTC system in Michigan is scattered among several state agencies. This leads to confusion in policy direction and budget development. The lack of a central point for quality management of the LTC system within the executive branch is a critical issue for consumers and policymakers alike.

### **Recommended Actions**

Align regulations, reimbursement, and incentives to promote this vision of quality and move toward that alignment in all sectors of the LTC system. Ensure that the consumer is the focus of quality assurance system.

### **Strategies / Action Steps**

1. Develop and implement use of consumer experience/consumer satisfaction surveys and measurements.
2. Include a strong consumer advocacy component in the new system.
3. Review and analyze current performance measures (both regulatory and non-regulatory).
4. Design performance measures that move Michigan's LTC system toward this vision of quality.
5. Invest quality management functions in a new Long-Term Care administration. The administration would improve quality by consolidating fragmented pieces of LTC, and defining and establishing broader accountability across the LTC array of services and supports. [Section 7 of the model Michigan Long-Term Care Consumer Choice and Quality Improvement Act in the appendix discusses some of the quality management functions in detail.]

### **Benchmarks**

1. Consumer determination of quality is the priority quality measure.
2. Person-centered planning is implemented throughout the LTC system.
3. Oversight of QM is established within LTC Commission and LTC administration.

**Recommendation # 8: Michigan Should Build and Sustain Culturally Competent, Highly Valued, Competitively Compensated, and Knowledgeable LTC Workforce Teams that Provide High Quality Care within a Supportive Environment and are Responsive to Consumer Needs and Choices.**

**Current Issues:** The long-term health care sector faces systemic challenges to attract and retain a qualified workforce. While the state's elderly population is projected to expand by 52% in the next 20 years, the traditional sources of new caregivers (women aged 25 to 44) will shrink by 10%.

High vacancy and turnover rates across the long-term care sector harm consumers, providers, workers, and ultimately our communities. Training for LTC workforce, particularly direct care workers, needs improvement across the sector. The package of wages, health care coverage, paid time off, and other benefits offered LTC employees are rarely competitive. While better compensation is not the single answer to workforce needs, it is an essential element in attracting and retaining a qualified team of individuals.

Long-term care, unlike many other business sectors, creates more jobs consistently every year. Unlike other employment sectors, long-term care has some natural career paths for advancements. Despite the growing number of jobs, the state lacks basic data about the current LTC workforce and projections for future employment.

To make careers in long-term care attractive, long-term care organizations—large and small—must embrace new participatory management and delivery systems that are consumer-centered and worker-friendly.

**Recommended Actions**

Develop and implement strategies to attract and recruit into long-term care careers an increasing number of capable, committed, energetic individuals. Improve LTC worker job retention to relieve current and future worker shortages, reduce labor-turnover costs, and continue high quality care and supports. Ensure competitive

wages/salary for LTC workers based on their level of education, experience, and responsibilities. Provide comprehensive affordable health care coverage for workers and their families. Promote adequate retirement planning for all employees. Develop and implement strategies that value contributions of the direct care worker as part of the LTC team in the provision of supports and services.

**Strategies / Action Steps**

1. Develop within the Michigan Works! Agencies (MWA) network, recruitment and screening protocols and campaigns that meet the needs of employers and job seekers.
2. Recast the state's Work First program to recruit, screen, train, and support individuals who demonstrate the desire, abilities, and commitment to work in LTC settings.
3. Develop recruitment campaigns to attract men, older workers, people of diverse cultural backgrounds, and people with disabilities to long-term care careers.
4. Mobilize state agencies' activities to include the research, exploration, explanation, and promotion of career opportunities in long-term care.
5. Improve and increase training opportunities for direct care workers to allow for enhanced skill development and employability.
6. Increase training opportunities for employers to improve supervision and create a positive work environment.
7. Reduce the rates of injury and exposure to hazardous materials to protect the current workforce and encourage new workers to join this workforce because of the sector's safety record.
8. Raise Medicaid reimbursement rates and other incentives so that the LTC workforce



receives compensation necessary to receive quality care as defined by the consumer.

9. Expand the ability of all long-term care employers and their employees, particularly their part-time employees, to access affordable health care coverage for themselves and their families.

The Department of Human Services (DHS), Michigan Department of Community Health (MDCH), Michigan Office of Services to the Aging (OSA), Department of Labor and Economic Growth (DLEG) and other state agencies should work collaboratively to identify standards and benchmarks ensuring that direct care workers are key partners and team members in providing quality care and supports.

10. Develop health professional curricula and reform current practice patterns to reflect the changing needs of the population. Recognize the unique needs of the elderly; people with chronic health problems; people approaching end-of-life; people of all ages with disabilities; and those in need of rehabilitative and restorative services across LTC and acute care settings.
11. LTC administration will track employment trends, including turnover rates.

#### **Benchmarks**

1. Measurable increase in LTC employer use of MWA services and in LTC employer hiring of Work First participants.
2. More qualified Work First participants are recruited and successfully employed in the LTC industry, while continuing their education for entry into licensed occupations.
3. Higher compensation packages and increased training opportunities.
4. Continuously and incrementally reduced turnover rates over the next decade.
5. All people working in LTC have access to affordable health care coverage.

6. Increased use of creative management and workplace practices.
7. Use of data and consumer satisfaction to inform a system of services, state policies, and employer practices that result in consumer-driven outcomes.
8. Increased opportunities and incentives for LTC employers and their supervisory personnel to improve supervisory and leadership skills to create positive workplace environments and relationships to reduce turnover.

#### **Recommendation # 9: Adapt Financing Structures that Maximize Resources, Promote Consumer Incentives, and Decrease Fraud.**

**Current Issues:** The task force bases its recommendations on these general funding assumptions:

1. Current resources are not sufficient to adequately fund needed supports and services.
2. The demand for long-term care supports and services will continue to increase as the population ages and as longevity increases.
3. Medicaid dollars available to meet anticipated demands are already being fully utilized within the state of Michigan, and federal support for future increases does not appear likely. While some efficiencies and cost savings of Medicaid dollars may be realized as part of the process of this review of the long-term care system, these dollars should not be expected to be sufficient to resolve existing financial shortages.
4. State legislative leaders and state policy makers must assure that non-Medicaid resources currently available to the state continue to be used to offer long-term care services and supports for Medicaid and non-Medicaid eligible individuals. This principle should reflect the need to maximize the availability and the flexibility of all funding sources in providing access to long-term care services and supports for residents of the state.

5. Leaders of the state's executive and legislative branches must acknowledge that while long-term care supports and services for the state's population must be adequately funded, this should not occur at the expense of, or detriment to, other vital state services such as public safety, public education, and the general public welfare. It is further incumbent upon the state's leadership and decision-makers to avoid the "pitting" of those in need of long-term care supports and services against the need for other public services in the allocation of currently scarce public resources.
6. The state must make a commitment to reinvesting all dollars realized from cost savings identified within the long-term care system back into long-term care supports and services. As changes to the system are recommended it is critical that any identified savings are not viewed as a way to help balance the state budget during a difficult economic period, but rather as a way to assure that an adequate system of long-term care supports and services is available to residents of the state of Michigan.

### **Recommended Actions**

Leaders of the state's executive and legislative branches must make a commitment to take necessary actions to adequately fund long-term care supports and services for residents of Michigan. Decisions for adequate funding of long-term care services should be based upon identified needs and not be made at the expense of other vital publicly funded state services.

### **Strategies /Action Steps**

1. Michigan should decouple its estate tax from the federal estate tax to make more revenue available.
2. Michigan should identify sources of non-federal tax revenue that are utilized to provide LTC and support services for Medicaid consumers, and create policies and procedures that will allow these funds to be used as local match to capture additional federal Medicaid dollars for long-term care and supports.

3. The Michigan Congressional Delegation should:
  - a. Advocate for the removal of the congressional barrier imposed on the development of Partnership program by states between Medicaid and long-term care insurance.
  - b. Strongly advocate that the federal government assume full responsibility for the health care needs of individuals who are dually eligible for Medicare and Medicaid.
  - c. Urge the Congress to revise the current Federal Medical Assistance Percentage (FMAP) formula to a more just methodology using Total Taxable Resources or a similarly broader measure and to shorten the time frame from the data reporting period to the year of application.
4. Subject to appropriate reviews for actuarial soundness, overall state budget neutrality, and federal approvals, Michigan should establish a mandatory estate preservation program instead of establishing a traditional Medicaid Estate Recovery Program.
5. Legislation that promotes the purchase and retention of long-term care insurance policies and that addresses ratemaking requirements, insurance standards, consumer protections, and incentives for individuals and employers should be drafted, reviewed, introduced, and enacted after review by a representative group of consumers, advocates, and providers.
6. Three specific strategies aimed at increasing the number of people in Michigan who have long-term care insurance should be implemented: a) gain federal approval for the use of the Long-Term Care Insurance Partnership Programs.; b) expand the state employees' self-funded, long-term care insurance program; and c) examine the possibility of a state income tax credit for purchase and retention of long-term care insurance.
7. Tax credits and tax deductions for the purchase of long-term care insurance

policies and for “out of pocket costs” for LTC should be considered.

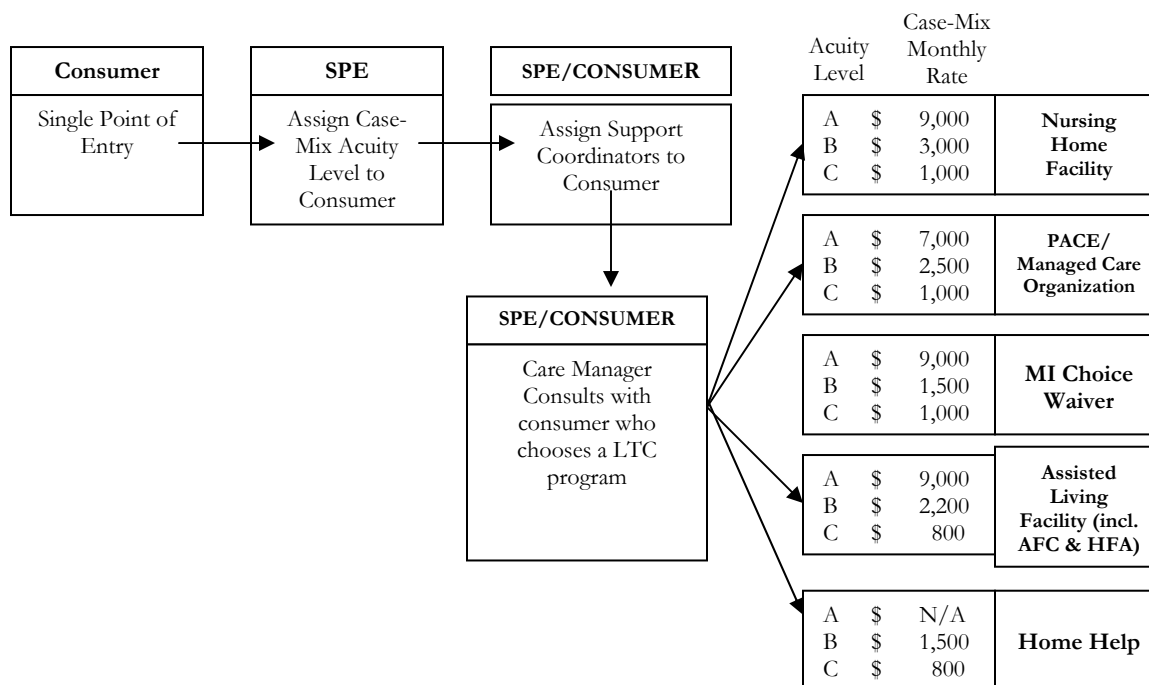
8. A “special tax exemption” for taxpayers who provide primary care for an eligible parent or grandparent (and possibly others) should be explored. Based upon a \$1,800 exemption proposed in legislation introduced in 2005, the Senate Fiscal Agency estimates cost to the state in reduced revenue at less than \$1 million.

As an initial step, Michigan should adopt a Case-Mix reimbursement system to fund LTC services and supports. This approach sets provider rates

according to the acuity mix of the consumers served. The higher the acuity, the higher the rate paid to the provider due to the resources needed to care for the consumers. As the long-term care system evolves, other appropriate funding mechanisms should also be considered and adopted.

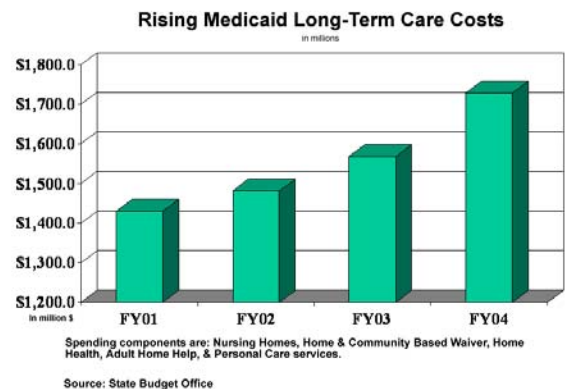
Below is a chart that illustrates how such a Case-Mix system would be operationalized. These are examples and not proposed rates, offered for the purpose of illustrating how a case-mix reimbursement might work.

**Case Mix Reimbursement Flow Chart**



9. Michigan should encourage and strengthen local and regional programs that support caregivers in their care giving efforts.
10. An ongoing and centralized data collection process by DHS of trusts and annuities information should continue to be used to guide the need for state regulation.
11. There should be ongoing review and strengthening, along with strict and consistent enforcement, of laws and regulations governing the inappropriate use of trusts and annuities for Medicaid eligibility.
12. There must be more frequent, vigorous, and publicized prosecution of those who financially exploit vulnerable individuals.
13. State agencies should cooperate in discovering and combating Medicaid fraud, and recovering funds paid for inadequate care.
14. New legislation for the regulation by the state of “trust mills” and annuity companies should be enacted. This legislation should address the prevention of abusive sales tactics through the implementation of insurance industry regulations, registration of out-of-state companies, and prescreening of sales materials.
15. Appropriate state agencies should analyze and quantify the relationship between public and private resources, including both time and money, spent on LTC. This analysis should be used as a way to obtain a match for federal Medicaid dollars.
16. The state should study and pursue aggressive Medicare recovery efforts.
17. Medicaid eligibility policies should be amended to:
  - a. Permit use of patient pay amounts for past medical bills, including past nursing facility bills.
  - b. Require full certification of all Medicaid nursing facilities.
  - c. Require dual certification of all nursing facilities.

18. The task force recommends full funding for an external advocacy agency on behalf of consumers accessing the array of supports and services overseen by the SPE system. Based on a conservative figure, the total budget line for this item would be \$4.3 million. Of the increase, \$2 million would be to bring the State Long-Term Care Ombudsman program into compliance with national recommendations; \$2.3 million would go to the external advocacy organization outlined in Section 8 of the Model Act.



### Benchmarks

1. Increased state and federal support will be available to implement Person-Centered Plans and consumer choice options.
2. A reduction of inappropriate asset and income sheltering will be achieved.
3. Improved federal-state funding partnership will be achieved.
4. An increase in the number of Michigan citizens with LTC insurance will be achieved.
5. An adequate allocation of finances and resources across the array of supports and services will reflect informed consumer choices in the delivery of LTC services and supports.

## Time Frames

Vision Statement: Within the next ten years, Michigan will achieve a high quality, easily accessible system of publicly and privately funded long-term care supports. These supports will include a full array of coordinated services available wherever an individual chooses to live and will be mobilized to meet the needs of each person with a disability or chronic condition, of any age, who needs and wishes to access them.

The arrangement and type of care and supports for each person will be determined by that person. Person-centered planning, which places the person as the central focus of supports and care planning, will be used to determine all facets of care and supports plans. Each person, and his or her chosen family, friends, or professionals, will initiate or re-start the process whenever the person's needs or preferences change. Selected milestones in reaching this objective include:

1. By January 1, 2006, the Department of Community Health will establish a person-centered planning protocol specific to long-term care consumers.
2. By October 1, 2006, every entity providing LTC services will have person-centered planning policies and training in place.
3. Phased-in implementation of the Single Point of Entry system will begin in 2005 with at least three sites launched before the end of 2006.
4. By the end of three years (2009), the SPE system will be operating throughout the whole state. The public awareness and education campaign will correspond with the launching of the SPE for each region, so that consumers can both gain awareness and find answers to their questions about LTC.
5. Effective October 1, 2005 and quarterly thereafter, MI Choice waiver program enrollment and funding will be incrementally increased to meet demand for MI Choice services to eliminate the need for waiting lists.
6. In the summer 2005, MDCH will seek approval from the federal government to amend the MI Choice waiver to allow for provision of its services in licensed assisted living settings.
7. By fall of 2005, introduce legislation to create the Long-Term Care Commission.
8. By the end of summer 2005, the Long-Term Care Administration (LTCA) will be created as part of MDCH and begin its quality management functions.
9. By the beginning of calendar year 2006, the LTCA (or MDCH) will begin to work with other state agencies to coordinate LTC workplace issues and conduct training.
10. Beginning with the 2006 fiscal year, Michigan Medicaid will begin the process of converting to a Case-Mix reimbursement system to fund LTC services and supports.
11. Beginning with 2006 and continuing over the following three years, develop health professional curricula, and reform current practice patterns.

## Recommendations for Further Study

The task force identified a number of issues that deserve greater attention than it was able to give them in its limited time. These include:

1. Examination of the Certificate of Need (CON) issues related to the supply of nursing facility beds.
2. Further exploration of managed care and other financial options as alternatives to the present system and the proposed case mix reimbursement system.
3. Eligibility inequities among the various programs.
4. Credentialing of consumer advocates.
5. Study of unlicensed assisted living services to determine if appropriate consumer protections are in place and enforced.
6. Budgeting and funding of outreach efforts, such as the public education campaign.
7. Study of reverse equity mortgages as a potential source of funding to allow individuals to age in place.
8. Study how the task force recommendations interact with other LTC systems.

## Conclusion

Michigan's Long-Term Care system, increasingly supported and influenced by Medicaid, has the long overdue need to link its many separate specialized programs into an array of services and supports for the state's consumers of LTC. The state's lack of a consistently articulated and implemented long-term care strategy has hindered the efforts of consumers and their families to make sense of the chaos. As the task force repeatedly heard in public comment, many consumers are unhappy with the experience in the long-term care system, and often feel that they have no recourse. Ongoing demographic, legal, and economic pressures will only make this situation worse unless the state adopts a new strategy to confront the systemic problems.

Principles such as "person-centered planning" and "money follows the person" must guide the administration of current programs and the development of new ones. Mechanisms to give dignity, control, and flexibility flow out of these principles. Barriers such as mixed eligibility criteria, quotas, and insufficient funding impede them. Consumers need to be educated about the available options, and be provided incentives, such as tax benefits for the purchase of LTC insurance, to personally prepare in advance for them. Strong prevention and caregiver support programs will lessen the need for entry into LTC programs, and organizational structures such as the Single Point of Entry (SPE) will help consumers once the need arises. Additional structures such as the Long-Term Care Commission will ensure that consumers and other interested parties stay engaged in the development and oversight process. A Long-Term Care Administration will centralize the state's efforts to conduct LTC policy and implementation, while monitoring and enforcing high quality standards.

However, LTC programs cannot adequately function without a highly qualified, fairly compensated and culturally diverse workforce. The shortage of personnel across the spectrum, from direct care workers to skilled SPE facilitators, will continue to hinder quality service delivery unless it is addressed. Although some financial "savings" may result from greater efficiency and the development of cost-effective alternatives to institutional care, the LTC system will continue to require a steady and strong commitment of support and resources from the legislature and governor's office to function. The aging of the population, if nothing else, will continue to pressure the system and keep LTC at the forefront of the state policy agenda. The need for fundamental change is upon the state now.

Michigan's current long-term care system is not sustainable. The barriers to progress can be challenged and overcome. The Michigan Medicaid Long-Term Care Task Force, consisting of a diverse group of people, struggled with many issues and developed the proposals shown above. It is now up to administrators, legislators, and people of goodwill at all levels to work collaboratively toward solutions designed to be effective and sustainable. Failure is not an option.

## Appendices

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## Acknowledgments

The Task Force would like to thank the many individuals and organizations for sharing their time, ideas, energy, and resources. The following list of individuals, organizations, agencies and offices reflects the broad scope of participants in this planning process. We would like to thank them for submitting comments, sending representatives, either in person or by conference call, and providing support for the many planning activities necessary for the task force to carry out its charge. Special thanks to Amy Slonim for facilitating the task force meetings. Thanks also to the many support staff members who helped prepare for meetings, handouts, presentations, and other task force business. We apologize in advance to any individual or organizational contributor who may not be identified by name. Please let us know if you would like your name added to the online version of this report.

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## Glossary

<b>Array of Services and Supports</b>	Also referred to as a “continuum of care” and an “integrated system of care.” An accessible, coordinated service system that assures those in need of services and supports have available a broad range of options that allows them to live and receive LTC services and supports where they choose.
<b>Assisted Living</b>	Assisted living is a marketing term often used by: 1.) state licensed adult foster care homes (as defined in MCL 400.703 through 400.407); 2.) state licensed homes for the aged (as defined in MCL 333.20106(3)); 3.) unlicensed settings, including housing with services contract establishment; and other supported independent living arrangements.
<b>Case Mix Adjustment/Reimbursement</b>	(Also known as acuity-based reimbursement) Under this strategy, payments are adjusted to reflect the actual (or expected) mix of care provided and the health status of patients treated. This is often combined with techniques that prospectively define reimbursement rates for various services or treatment of specific types of conditions (diagnosis-related groups). Many states use case mix reimbursement systems for nursing facilities. (Source: National Conference of State Legislatures at <a href="http://www.ncsl.org/programs/health/forum/cost/strat7.htm">http://www.ncsl.org/programs/health/forum/cost/strat7.htm</a> ) (Also known as acuity-based reimbursement).
<b>Consumer-Directed Care</b>	Consumer directed care integrates and maximizes consumer choice and control into all aspects of home and community-based care. One of the most critical tenets of consumer direction is the belief that individuals have the primary authority to make choices that work best for them regardless of their age or disability. Choice and control are key elements of consumer-directed care.
<b>Home and Community-Based Services</b>	<p>Home and community-based services are long-term support services for people who need assistance with activities of daily living (ADLs), such as eating, bathing and dressing, or instrumental activities of daily living (IADLs), such as preparing a meal or managing medications, in order to live at home or in the community. They may, depending on the program, include any of the following types of services.</p> <ul style="list-style-type: none"> <li>• Personal care, homemaker, and chore assistance.</li> <li>• Adult day programs that provide therapeutic activities, meals, and transportation.</li> <li>• Respite care or substitute care during the day and on weekends, evenings, and emergencies, or as short stays in long-term care facilities, to provide relief to the family caregiver.</li> </ul>

	<ul style="list-style-type: none"> <li>• Home modifications and personal care supplies.</li> <li>• Services in residential care facilities, including assisted living, foster care, and board and care homes.</li> <li>• Care planning and case management, including a comprehensive assessment by a case manager and the network of professionals and programs appropriate for providing care.</li> <li>• Vocational services, including supported employment programs, vocational evaluations, job training and placement, and work adjustment programs.</li> <li>• Other quality of life services, such as recreation and leisure activities, transportation, and early intervention programs.</li> </ul> <p>(Source: National Conference of State Legislatures at <a href="http://www.ncsl.org/programs/health/forum/cost/strat7.htm">http://www.ncsl.org/programs/health/forum/cost/strat7.htm</a>)</p>
<b>Long-Term Care Insurance</b>	An insurance policy to cover the cost of long-term custodial care in a nursing facility or at home. (Source: State of Michigan Department of Labor and Economic Growth)
<b>Long-Term Care Workforce</b>	Paid and unpaid individuals and agencies that provide direct care and/or supportive services across the continuum.
<b>Money Follows the Person</b>	<p>“Money follows the person” refers to a system of flexible financing for long-term services that enables available funds to move with the individual to the most appropriate and preferred setting as the individual’s needs and preferences change. To the individual, the movement of these funds may appear seamless. People receiving supports, not providers or program managers, drive resource allocation decisions as they move through the long-term care system. (Source “Money Follows the Person and Balancing Long-Term Care Systems: State Examples,” CMS, currently available at: <a href="http://www.cms.hhs.gov/promisingpractices/mfp92903.pdf">http://www.cms.hhs.gov/promisingpractices/mfp92903.pdf</a>)</p>
<b>Nursing Facility</b>	<p>A licensed institution primarily engaged in providing to residents:</p> <ul style="list-style-type: none"> <li>• Skilled nursing care and related services for residents who require medical or nursing care</li> <li>• Rehabilitative services for the rehabilitation of injured, disabled, or sick persons, and</li> <li>• On a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board), which can be made available to them only through institutional facilities.</li> </ul> <p>• Source: Social Security Act 1919b, 42 U.S.C. §1396r</p>
<b>Person-Centered Planning</b>	“Person-centered planning” means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote

	community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires. Source: Michigan Mental Health Code, MCLA 330.1700 (g)
<b>Person-Centered Planning Facilitator</b>	A person-centered planning facilitator is an individual who has been chosen by the person to assist them and their invited guests through the person-centered planning process. In some cases, the consumer may choose to act as their own person-centered planning facilitator. The facilitator should guide the person and their team through the development of an action plan. He/she should take on an active role promoting the person, reframing behavior as communication, identifying barriers, and encouraging the full and meaningful participation of each guest. (Source: Presentation to the Long-Term Care Task Force by Dr. Sally Burton Hoyle, Autism Society of Michigan.)
<b>Single Point of Entry</b>	“Single Point of Entry” agencies will provide information, referral, and assistance to individuals seeking services and supports for long term care. Assistance will include case and supports coordination, authorizing (but not providing) Medicaid services. They also will serve as a resource on long-term care for the community at large and caregivers. Use of the SPE agency is mandatory for individuals seeking to access publicly funded programs.

# Model Act

## MICHIGAN LONG-TERM CARE CONSUMER CHOICE AND QUALITY IMPROVEMENT ACT

FEBRUARY 14, 2005

### Sec. 1 Short title

This act shall be known and may be cited as the "Michigan Long-Term Care Consumer Choice and Quality Improvement Act."

### Sec. 2 Definitions

1) Definitions: When used in this Act, the following words shall have the following meanings:

(a) "Authority" means the entity created pursuant to section 4 of this act.

(b) "Commission" means the long-term care commission established pursuant to section 3 of this act.

(c) "Consumer" means an individual seeking or receiving public assistance for long-term care.

(d) "Department" means the department of community health.

(e) "Director" means the director of the department.

(f) "Long-term care" means those services and supports provided to an individual in a setting of his or her choice that are evaluative, preventive, habilitative, rehabilitative or health related in nature.

(g) "Medicaid" means the program for medical assistance established under title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396f, 1396g-1 to 1396r-6, and 1396r-8 to 1396v, and administered by the department under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b.

(h) "Person-centered planning" means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.

(i) "Primary consumer" means the actual user of long-term care services.

(j) "Secondary consumer" means family members or unpaid caregivers of consumers.

(k) "Single points of entry" means those entities created pursuant to section 6 of this act.

(l) "Transition services" means those services provided to assist an individual in moving from one setting to another setting of his or her choice and may include, but is not limited to, the



payment of security deposits, moving expenses, purchase of essential furnishings, and purchase of durable medical equipment.

### **Sec. 3 Findings and purpose**

1) The legislature finds that long-term care services and supports are critically important for Michigan citizens, their families, caregivers and communities, that the need for long-term care services and supports is expected to increase substantially as the number of older people and people with disabilities increases, that consumers will be best served by the creation and continuing refinement of a carefully coordinated long-term care system that promotes healthy aging, consumer education and choice, innovation, quality, dignity, autonomy, the efficient and effective allocation of resources in response to consumer needs and preferences, and the opportunity for all long-term care consumers, regardless of their age or source of payment, to develop and maintain their fullest human potential.

2) Consistent with section 51 of article IV of the state constitution of 1963, which declares that the health of the people of the state is a matter of primary public concern, and as required by section 8 of article VII of the state constitution of 1963, which declares that services for the care, treatment, education or rehabilitation of persons with disabilities shall always be fostered and supported, the department is charged with the primary responsibility for ensuring the development and availability of a system of long-term care as described in this act.

3) The purpose of this Act is to ensure all of the following:

(a) That consumers have access to a well-coordinated, comprehensive, adequately funded and dynamic array of long-term services and supports including but not limited to assessment, care planning, in-home services and supports, a range of assisted living options, care management services, respite care services, nursing facility care, hospice care, primary care, chronic care management, supports coordination, and acute care. This array of services and supports must be designed through a person-centered planning process to meet existing consumer needs and preferences, be flexible and responsive to changing consumer needs and preferences, and encourage innovation and quality;

(b) That consumers are provided with sufficient education and support to make informed choices about their long-term care service and supports options;

(c) That the system is consumer focused, embraces person centered planning, and fosters the creation of innovative long-term care options;

(d) That services and supports are provided in the most independent living setting be consistent with the consumer's needs and preferences;

(e) That access to long-term care services and supports is determined by a uniform system for comprehensively assessing abilities and needs;

(f) That public resources purchase, permit, and promote high quality settings, services, and supports through:

- (1) adequate and consistent monitoring of publicly funded settings, services and supports;
- (2) consistent and appropriate enforcement of statutory and regulatory standards;
- (3) monitoring of outcomes of long-term care for quality and adherence to the consumers' expressed preferences; and

(4) swift and effective remedies if services, supports, or settings fail to meet quality standards or to promote long-term care consumers' dignity, autonomy, and choice.

(g) The goal of the system shall be continuous quality improvement focused on consumer satisfaction and the consistent achievement of clear standards concerning the health, safety, autonomy, and dignity of long-term care managers; family members; and others when appropriate. These mechanisms shall assist regulators and policy makers in evaluating quality and consumer satisfaction and in determining necessary adaptations and improvements in the dynamic long-term care system.

(h) That long-term care services are coordinated in a way that minimizes administrative cost, eliminates unnecessarily complex organization, minimizes program and service duplication, and maximizes the use of financial resources in meeting the needs and preferences of long-term care consumers.

(i) That the state collects, analyzes, and distributes to the public on an ongoing basis complete data regarding current utilization of long-term care services and supports, unmet needs, consumer preferences, demographic data, workforce capacity, and other information that will assist the state in the continuing coordination and refinement of its long-term care system. In addition, ensure the state publishes periodic reports that assess the adequacy and efficacy of the reimbursement and enforcement systems and identify areas requiring improvement, unmet needs, successful innovations, and best practices.

(j) That state and the long-term care industry build and sustain an adequate, well-trained, highly motivated and appropriately compensated workforce across the long-term care continuum.

(k) That all stakeholders including consumers and their families and advocates, providers, representatives of the long-term care workforce, public officials and others have a continuing opportunity for meaningful input in the development and refinement of the long-term care system.

#### **Sec. 4 Long-term care commission**

1) A commission on long-term care is hereby established, to be appointed by the governor.

2) The commission shall consist of twenty-five members appointed by the governor. Commission membership shall consist of fourteen consumers, of which at least fifty percent are primary consumers and of those primary consumers at least fifty percent shall be users of Medicaid services, the remainder comprised of secondary consumers and consumer organization representatives, seven providers or provider organization representatives, three direct care workers and one member with expertise in long-term care research from a university. Overall commission membership shall also reflect the geographic and cultural diversity of the state.

3) One representative each from the single point entry network, the State Long-Term Care Ombudsman, the designated protection and advocacy system, the Department of Community Health, the Department of Human Services and the Department of Labor and Economic Growth, all of whom shall serve in non-voting supporting roles as ex-officio members. Staff from the Medical Services Administration and the Office of Services to the Aging shall serve as resources to the commission and shall assist the commission as needed.

4) Voting member terms shall be three years, staggered to ensure continuity and renewable under the appointment process. If a vacancy occurs during the term of a voting member, the governor shall appoint a replacement to serve out the remainder of the term and shall maintain the same composition for the commission as set forth in sec. 4(2).

5) Commissioners are entitled to receive a stipend, if not otherwise compensated and reimbursement for actual and necessary expenses while acting as an official representative of the commission as defined by commission policies and procedures. Commission policies and reimbursement shall establish and practice full accommodation to individual support needs of commission members, including their direct care and support workers or personal assistants, support facilitation or other persons serving them as secondary consumers.

6) The governor shall designate one person from among the consumer membership to serve as chairperson of the commission, who shall serve at the pleasure of the governor.

7) The commission shall do all of the following:

(a) Serve as an effective and visible advocate for all consumers of long-term care supports and services.

(b) Participate in the preparation and review, prior to the submission to the governor, of an ongoing, comprehensive statewide plan and budget for long-term care services and supports design, allocations and strategies to address and meet identified consumer preferences and needs.

(c) Ensure the broadest possible ongoing public participation in statewide planning as part of subsection (1)(b).

(d) Ensure broad, culturally competent, and effective public education initiatives are ongoing on long-term care issues, choices and opportunities for direct involvement by the public.

(e) Evaluate the performance of the designated single point of entry agencies on an annual basis and make its report and recommendations for improvement to the single point of entry system available to the legislature and the public.

(f) Continuously monitor spending and budget implementation, including how well expenditures match policy decisions and initiatives based on consumer preferences and needs.

(g) Meet at least six times per year.

(h) A quorum of the commission shall consist of at least fifty percent of the voting membership, provided at least eight consumer members are present or participating. Participation may be by telephone or other means, in accordance with other statutory provisions and as determined by the commission.

## **Sec. 5 Long-term care administration**

1) (Insert here language directing how the administration will be created, where it will be located, etc.).

2) The long-term care administration shall do all of the following:

(a) Serve as an effective, visible, and accessible advocate for all consumers of long-term care supports and services.

(b) Prepare and implement an ongoing, comprehensive statewide plan for the governor for long-term care services and supports design, administration and oversight to ensure delivery of an organized system which meets identified consumer preferences and needs.

(c) Develop and implement an ongoing budget that ensures state financial resources follow consumer preferences under the comprehensive state plan for review by the commission prior to submission to the governor.

(d) Ensure the broadest possible ongoing public participation in statewide planning as part of subsection (2)(b).

(e) Recommend to the department director designations and de-designations of the state's single points of entry (SPE) network agencies under established guidelines; recommend contract awards; establish performance and review standards for SPE agencies; receive standardized annual and other reporting from the agencies.

(f) Ensure broad, culturally competent and effective public education initiatives are ongoing on long-term care issues and choices.

(g) Advise the governor, the legislature, and directors of relevant agencies and department heads regarding changes in federal and state programs, statutes, and policies.

(j) As part of its ongoing planning, identify and address long-term care workforce capacity, training and regulatory issues in both the public and private sectors.

(k) Retain state approval over proposed changes in Medicaid policy and services related to long-term care before publication and comment; continually reform eligibility policy to improve timeliness and access.

(l) Develop and maintain a comprehensive state database and information collection system on long-term care service and supports capacities and utilization that is publicly accessible, while protecting individual consumer privacy, for the purposes of individual and state-aggregated planning, forecasting, and research.

(m) Ensure all necessary and vital linkages among acute, primary and chronic care management supports and services are maintained and continually strengthened to complement, leverage, and enhance services, supports and choices in the long-term care system.

(n) Develop and implement policies and procedures that will facilitate efficient and timely transition services for individuals moving from a nursing facility to home or apartment in the community. Services may include, but are not limited to payment of security deposits, moving expenses purchase of essential furnishings and durable medical equipment.

(o) Identify and implement progressive management models, culture change, and indicated administrative restructuring to maximize efficiency, optimize program design and services delivery; provide technical assistance in these areas to providers and interested members of the public.

(p) Establish a comprehensive, uniform, and enforceable consumer rights and appeals system.

## **Sec. 6 Single points of entry**

1) It is the intent of the legislature that locally or regionally based single points of entry for long-term care serve as visible and effective access points for persons seeking long-term care and promote consumer education and choice of long-term care options.

2) The director shall designate and maintain locally and regionally based single points of entry for long-term care that will serve as visible and effective access points for persons seeking long-term care and promote consumer choice.

3) The department shall monitor designated single points of entry for long-term care to:

(a) prevent bias in eligibility determination and the promotion of specific services to the detriment of consumer choice and control;

(b) Review all consumer assessments and care plans to ensure consistency, quality and adherence to the principles of person-centered planning and other criteria established by the department;

(c) Assure the provision of quality assistance and supports;

(d) Assure that quality assistance and supports are provided to applicants and consumers in a manner consistent with their cultural norms, language of preference, and means of communication.

(e) Assure consumer access to an independent consumer advocate.

4) The department shall establish and publicize a toll-free telephone number for those areas of the state in which a single point of entry is operational as a means of access to the single point of entry for consumers and others.

5) The department shall promulgate rules establishing standards of reasonable promptness for the delivery of single point of entry services and for long-term care services and supports.

6) The department shall require that designated single points of entry for long-term care perform the following duties and responsibilities:

(a) Provide consumers and any others with information on and referral to any and all long-term care options, services, and supports;

(b) Facilitate movement between supports, services, and settings in an adequate and timely manner that assures the safety and well-being of the consumer;

(c) Assess a consumer's eligibility for all Medicaid long-term care programs utilizing a comprehensive level of care tool;

- (d) Assist consumers to obtain a financial determination of eligibility for publicly funded long-term care programs;
  - (e) Assist consumers to develop their long-term care support plans through a person-centered planning process;
  - (f) Authorize and, if requested, arrange for needed transition services for consumers living in nursing facilities;
  - (g) Work with consumers in acute and primary care settings as well as community settings to assure that they are presented with the full array of long-term care options;
  - (h) Re-evaluate consumers' need and eligibility for long-term care services on a regular basis;
  - (i) Perform the authorization of Medicaid services identified in the consumer's care supports plan.
- 7) The department shall, in consultation with consumers, stakeholders, and members of the public, establish criteria for the designation of local or regional single points of entry for long-term care. The criteria shall assure that single points of entry for long-term care:
- (a) Are not a provider of direct Medicaid services. For purpose of this act, care management and supports coordination are not defined as a direct Medicaid service;
  - (b) Are free from all legal and financial conflicts of interest with providers of Medicaid services;
  - (c) Are capable of serving as the focal point for all persons seeking information about long-term care in their region, including those who will pay privately for services;
  - (d) Are capable of performing consumer data collection, management, and reporting in compliance with state requirements;
  - (e) Have quality assurance standards and procedures that measure consumer satisfaction, monitor consumer outcomes, and trigger care and supports plan changes;
  - (f) Maintain internal and external appeals processes that provide for a review of individual decisions;
  - (g) Complete an initial evaluation of applicants for long-term care within two business days after contact by the individual or his or her legal representative; and
  - (h) In partnership with the consumer, develop a preliminary person-centered plan within seven days after the applicant is found eligible for services.
- 8) Designated single points of access for long-term care that fail to meet the above criteria, and other fiscal and performance standards as determined by the department, may be subject to de-designation by the department.
- 9) The department shall promulgate rules establishing timelines of within two business days or less for the completion of initial evaluations of individuals in urgent or emergent situations and shall by rule establish timelines for the completion of a final evaluation and assessment for all individuals, provided such timeline is not longer than two weeks from time of first contact.

10) The department shall solicit proposals from entities seeking designation as a single point of entry and shall designate at least three agencies to serve as a single point of entry in at least three separate areas of the state. There shall be no more than one single point of entry in each designated region. The designated agencies shall serve in that capacity for an initial period of three years, subject to the provisions of Sec. 4(3).

11) The department shall evaluate the performance of the designated agencies on an annual basis and shall make its report and recommendations for improvement to the single point of entry system available to the legislature and the public.

12) No later than October 1, 2008, the department shall have a designated agency to serve as a single point of entry in each region of the state. Nothing in this section shall be construed to prohibit the department from designating single points of entry throughout the entire state prior to said date.

13) The department shall promulgate rules to implement this act within six months of enactment.

## **Sec. 7 Quality**

1) The authority shall have a continuing responsibility to monitor state agencies' performance in responding to, investigating, and ensuring appropriate outcomes to complaints and in performing its survey and enforcement functions. The Long-Term Care Administration shall issue regulations and policy bulletins, as appropriate, and take other appropriate action to improve performance or address serious deficiencies in state agencies' practices with regard to handling complaints and in performing survey and enforcement functions.

2) The authority shall establish a single toll free hotline to receive complaints from recipients of all Medicaid funded long-term care services and settings. State employees responsible for this function shall:

(a) Staff the complaint line 24 hours a day, 7 days per week;

(b) Be trained and certified in information and referral skills;

(c) Conduct a brief intake;

(d) Provide information and referral services to callers including information about relevant advocacy organizations; and

(e) Route the call to the appropriate state agency or advocacy organization to record and respond to the consumer's concern. Relevant state agencies shall ensure on-call staff is available after hours to respond to any calls that are of an emergency nature. The authority shall ensure that hotline staff are consistently informed how to contact on-call staff at all relevant state agencies to which long-term care complaints may be referred.

3) The administration shall also ensure that consumers can file complaints about any Medicaid funded long-term care setting or service using a simple, web-based complaint form.

4) The administration shall publicize the availability of the 24 hour hotline and web-based complaint system through appropriate public education efforts.

5) The administration shall form a workgroup to determine if state agencies' complaint protocols ensure a timely and complete response and to monitor for appropriate outcomes. The workgroup

shall also address whether state agencies are performing their survey and enforcement functions in the most effective manner and if their practices promote quality and person-centered planning.

(a) The workgroup shall be comprised of a minimum of fifty percent consumers and/or consumer advocacy groups. The remainder of the workgroup shall include the State Long-Term Care Ombudsman and/or his/her representative, long-term care providers, a representative from the designated protection and advocacy system, and representatives from the departments that enforce the regulations in long-term care facilities.

(b) The workgroup will be charged with examining the number of consumer complaints received, the timeliness of response to these complaints, the process used by state investigators for these complaints, and the resolutions of these concerns. The workgroup will utilize existing resources such as Auditor General reports on state agencies that regulate long-term care facilities or services and any additional data it requires to perform its duties. Based on these findings, the workgroup will issue recommendations to the administration and to the director.

(c) The workgroup shall also be charged with a comprehensive review of state law and policy, including licensing laws and regulations, receivership provisions, and other mechanisms for regulating long-term care services to determine whether these laws and policies should be deleted, amended, or modified to promote quality, efficiency, and person-centered planning or to reflect changes in the long term care system. The workgroup shall issue recommendations to the authority and to the director.

6) The departments responsible for licensing of long-term care settings shall, within twelve months of the date of enactment of this statute, promulgate rules to establish a process for identifying all licensed long-term care settings which, absent intervention by the state, are likely to either close or in which care is likely to diminish or remain below acceptable standards. In promulgating these rules, the departments shall consider, but not be limited to, the facility's financial stability, administrative capability, physical plant, and regulatory history.

7) If a department has a reasonable suspicion that a licensed facility lacks administrative capability, financial stability, financial capability, or is not structurally sound, it shall have the right to request any and all relevant documentation including, but not limited to, independent audits of the facility, credit reports, physical plant inspections by appropriate professionals, and other relevant information. It may also investigate and consider factors such as whether the facility has filed for bankruptcy or whether foreclosure has been filed, consistently declining occupancy rates, chronic noncompliance, or other relevant information.

8) In the event a department identifies a facility to be nonviable, it shall take appropriate measures to protect the health and safety of the residents, which may include the following:

(a) The prompt appointment of a temporary manager or receiver with authority to take all actions necessary for the purpose of stabilizing the facility and protecting the residents, including:

1. Making all improvements necessary to ensure residents receive services that meet or exceed minimum regulatory standards; or
2. If necessary and appropriate, arranging for the safe and orderly transfer of residents out of the facility consistent with their person-centered plan and choices.

(b) Redistributing beds within the community to other facilities or making funding available in other long-term care settings, including home and community based care.



9) The State shall ensure that relevant state agencies have sufficient staff to meet all statutory or regulatory time frames for the completion of their responsibilities; effectively and expediently monitor services, supports, and facilities; respond to complaints; and enforce existing state laws and regulations regarding minimum standards for long-term care services, supports, and facilities.

## **Sec. 8 Consumer advocate**

1) No later than six months after the enactment of this act, the governor shall designate an agency with the independence and capacity to serve as an advocate for long-term care consumers, as set forth in this section. This designation shall continue indefinitely unless, for good cause shown, the agency is unwilling or incapable of performing its duties as set forth in this section.

2) The designated agency shall have the responsibility to identify, investigate, and resolve complaints concerning services provided pursuant to this act; shall assist applicants for long-term care who have been denied services and supports; and shall pursue legal, administrative and other remedies at the individual and systemic level to ensure the protection of and advocacy for the rights of long-term care consumers.

3) The designated agency shall have access at reasonable times to any consumer in a location in which services and supports are provided.

4) The designated agency shall have access to the medical and mental health records of long-term care consumers or applicants for long-term care under any of the following conditions:

(a) With consent of the consumer or applicant or his or her legal representative;

(b) Without consent, if the consumer is unable to give consent and there is no legal representative or the state is the individual's representative and the designated agency has received a complaint or has probable cause to believe that abuse or neglect has occurred; or

(c) Without consent, if the consumer is unable to give consent and the legal representative has refused or failed to act on behalf of the individual and the designated agency has received a complaint or has probable cause to believe that abuse or neglect has occurred.

5) Records requested by the designated agency shall be made available for review and copying within three business days or, in the event of death or a request made pursuant to 4(b) or (c), within 24 hours.

6) The designated agency shall maintain an office in each of the service areas of the single points of entry.

7) The designated agency shall coordinate its activities with those of the state long-term care ombudsman and the designated protection and advocacy system.

8) The designated agency shall prepare an annual report and provide information to the public and to policymakers regarding the problems of long-term care consumers.

9) The legislature shall appropriate sufficient funds to enable the designated agency to perform its duties.